

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36086

State File No. _____

Registrar's No. **10415**

FILED DEC 9 19818

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 mos. 7 days**
In this community **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Margaret Armour**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Lery** 6. (c) Age of husband or wife if alive **34** years
7. Birth date of deceased **Feb 2 1918**
(Month) (Day) (Year)

8. AGE: Years **25** Months **9** Days **23** If less than one day hr. _____ min.

9. Birthplace **St Louis** (City, town, or county) **mo 0** (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business

MOTHER FATHER { 12. Name **William White**
13. Birthplace **Jackson** (City, town, or county) **Miss** (State or foreign country)
14. Maiden name **Anna Dorsey**
15. Birthplace **St Louis Co** (City, town, or county) **mo 0** (State or foreign country)

16. (a) Informant **William White**

(b) Address **3330A Hickory St**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-29-43** (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **J. H. Randle & Son**

(b) Address **3133 Bell Ave**

19. (a) **NOV 28 1943** (Date received local registrar) (b) **J. T. Bruck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **2204 Spruce** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **25**, year **1943** hour **6** minute **P** M. **June**

21. I hereby certify that I attended the deceased from **18**, 19 **43** to **November 25**, 19 **43**

that I last saw h. er alive on **November 25**, 19 **43** and that death occurred on the date and hour stated above.

Immediate cause of death: **Bronchopneumonia (autopsy)**
Perinephritic Abscess

Due to **No pregnancy**

Due to **156**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **G. K. Fleet** (M. D. _____)
Address **2601 Whittier** Date signed **11/27/43**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. 2698

P. O. Address 2769 Chouteau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.